BEFORE THE MINNESOTA

BOARD OF DENTISTRY

In the Matter of
John Poage, D.D.S.
License No. D9304

STIPULATION AND ORDER FOR CONDITIONAL LICENSE

TO: John Poage, D.D.S. ("Licensee"), and his attorney, Philip G. Villaume, 5200 Willson Road, Suite 150, Edina, MN 55424

The Minnesota Board of Dentistry ("Board") is authorized pursuant to Minn. Stat. ch. 150A, § 214.10, and § 214.103 to license and regulate dentists, to refer complaints against dentists to the Attorney General for investigation, and to take disciplinary action when appropriate.

The Board received a complaint(s) against John Poage D.D.S. ("Licensee"). The Board's Complaint Committee ("Committee") reviewed the complaint(s) and referred the matter to the Attorney General's Office for investigation. Following the investigation, the Committee held a conference with Licensee on January 16, 2004. The Committee and Licensee have agreed that the matter may now be resolved by this stipulation and order.

STIPULATION

IT IS HEREBY STIPULATED AND AGREED by and between Licensee and the Committee as follows:

A. Jurisdiction. Licensee holds a license to practice dentistry in the State of Minnesota from the Board and is subject to the jurisdiction of the Board with respect to the matters referred to in this stipulation. Licensee states that he does not hold a license to practice

dentistry in any other jurisdiction and does not hold any other professional or occupational licenses.

B. Facts. This stipulation is based upon the following facts:

Substandard Periodontal Treatment

1. Licensee has failed to provide appropriate periodontal treatment to one or more of his patients. Examples include the following:

a. Licensee failed to follow up on periodontal treatment provided to teeth #22 and 23 of patient 1, and on the clinical indicators suggesting that the patient had chronic periodontitis, and billed the patient for providing osseous surgery which Licensee failed to provide, as follows:

1) On April 9, 1996, Licensee provided a new patient examination and a prophylaxis to patient 1, and took a panogram and four bitewing radiographs. The results of periodontal probing indicated the patient had pockets of 4mm on teeth #19, 20, 30, and 31; 5mm on teeth #15 and 22; and a 6mm pocket on the distal aspect of tooth #18. Licensee noted he planned to have the patient to return for an hour of scaling and root planing.

2) On June 13, 1996, one of Licensee's dental hygienists scaled and root planed the left side of patient 1's mouth (teeth #9-16 and 17-24) and noted she also "spot scaled" other areas of the patient's mouth.

3) On June 18, 1996, Licensee noted, "Patient presented [with] perio[dontal] abscess [on tooth] #22, 23, scaled out, irrigated [with] Peridex – 6mm #22 mes[ial]. ℞ – Peridex."

4) On November 27, 1996, patient 1 was seen for an examination and a "pro perio." The results of periodontal probing showed the patient had pockets of 5mm on teeth #15 and 22; and 6mm on the distal aspect of tooth #18, indicating that despite the scaling and root planing treatment there was no improvement on teeth 15, 18, and 22.

5) On June 26, 1997, patient 1 was seen for a "perio maintenance" appointment. It was noted that Licensee examined the patient's teeth and that four bitewing radiographs were taken. The results of periodontal probing indicated the patient had pockets of 5mm on teeth #18, 28 and 29; a 6mm pocket on tooth #30; and 5 and 6mm pockets on tooth #31.

6) On August 25, 1997, Licensee saw patient 1 and noted only, "Give Perioguard, "and "Needs surgery #19."

7) On September 5, 1997, Licensee noted he provided "Surgery," to teeth #18 and 19 of patient 1. Licensee entered a CDT code to indicate he provided osseous surgery to those teeth. Licensee also noted he had probed teeth #18-20 and had found pockets of 4 and 5mm on tooth #18, 6 and 8.5mm on tooth #19, and 5 and 6mm on tooth #20. According to one of Licensee's registered dental assistants, Licensee administered local anesthetic to the patient and but did not make any incisions into the patient's gingiva. Instead, Licensee spent approximately three to five minutes scaling the buccal aspect of tooth #19. Licensee did not provide the patient with any special postoperative instructions.

8) On November 4, 1997, two months after he documented and billed for performing osseous surgery on teeth #18 and 19 of patient 1, Licensee noted that he referred the patient to a periodontist for treatment of tooth #19 only. The patient's chart contained no documentation of the patient's follow-up with a periodontist.

9) On August 31, 1998, patient 1 was seen for a "perio maintenance" appointment, the patient's teeth were examined, and bitewing radiographs were taken. The results of periodontal probing indicated the patient had pockets of 4-6mm on teeth #2, 14, 15, 18-20, 23, 27-31. Despite this indication of chronic periodontal disease, Licensee noted the following plan, "Re-eval[uate] in 4 months – advised to (sic) patient [of] possibility of SC/RP [scaling and root planing]." Licensee's plan failed to provide for further periodontal treatment for patient 1 and/or to re-refer the patient to a periodontist. At his conference with the Committee, Licensee stated that he was without sufficient knowledge to admit or deny that his plan failed to provide for further periodontal treatment for patient 1 and/or to re-refer the patient to a periodontist.

b. Licensee failed to treat patient 2's periodontal disease prior to placing crowns and bridges on the patient's teeth, as follows:

1) Licensee treated patient 2 (YOB: 1914) from August 16, 1983, to September 15, 1998.

2) In June 1985, Licensee placed a bridge on teeth #1-5 of patient 2. In July 1987, he replaced that bridge with a cantilever bridge on teeth #2 through 6. From 1987 to 1991, patient 2 received a prophylaxis four times, approximately once a year. In June 1991, tooth #4 became infected and was subsequently extracted. Periapical radiographs dated June 24, 1991, showed the presence of periodontal disease. However, Licensee failed to treat the patient's periodontal condition and in July 1991, the 1987 bridge was replaced with a new one on teeth #2 through 8.

3) After receiving the new bridge, patient 2 had a prophylaxis appointment on September 3, 1991, and at this appointment Licensee and his staff first recorded

the results of periodontal probing. However, only one number was entered on the charting form, indicating a 6mm pocket on the mesial aspect of tooth #18. At the patient's next prophylaxis appointment on May 13, 1992, only one number was entered on the chart, indicating a 6mm pocket on the mesial aspect of tooth #2. Though this tooth was the anchor for the 1991 bridge on teeth #2-5, 6-8, Licensee failed to note a plan to treat tooth #2 or to refer the patient to a periodontist. At his conference with the Committee, Licensee stated that he was without sufficient knowledge to admit or deny that he failed to refer the patient to a periodontist.

4) On May 27, 1993, Licensee replaced the 1991 bridge on teeth #2-8. On October 23, 1997, he replaced the 1993 bridge without addressing the patient's compromised periodontal status during that time.

5) At subsequent prophylaxis appointments on November 11, 1992, August 12, 1996, and June 3, 1997, the only entries made on the patient's periodontal charting forms were the appointment dates and notes concerning the health of the patient's husband. Other than these notes, each form contained no indication that periodontal probing had been performed on the patient's teeth. For the patient's prophylaxis appointments on May 13, 1993, May 10, 1994, and May 10, 1995, no entries were made on the periodontal charting forms.

c. Licensee failed to appropriately treat patient 3's compromised periodontal status, specifically associated with teeth #14 and 15, or to refer the patient to a periodontist, which eventually resulted in the extraction of those teeth. In addition, Licensee inappropriately performed osseous surgery on teeth #14 and 15 two months prior to their extraction, as described below:

1) On November 6, 1987, patient 3 was seen for an examination and prophylaxis, and four bitewing radiographs. Results of periodontal probing indicated the patient

had 6mm pockets on teeth #2 and 3, a 5mm pocket in tooth #4, an 8mm pocket on the disto–lingual aspect of tooth #14, 6 and 8mm pockets on the mesio-buccal and mesio-lingual aspect of tooth #15, 4 and 5mm pockets on teeth #19-21, a 4mm pocket on tooth #27, 4 and 5mm pockets on teeth #28 and 29, and 5 and 6mm pockets on teeth #30 and 31. Licensee recommended the patient return for scaling and root planing which was completed at two appointments in December 1987.

2) Though Licensee recommended the patient receive prophylaxes at four-month intervals, from March 8, 1988, until February 13, 1996, patient 3 received prophylaxes sporadically; sometimes coming in after five months and occasionally going as long as a year between prophylaxis appointments. During that time the patient's pockets improved initially but then fluctuated between 6 and 8 mm in the area of teeth #14 and 15, and 4 and 6mm in the patient's other posterior teeth. According to periodontal probing recorded on February 13, 1996, there was a 7mm pocket on the disto-buccal aspect of tooth #2, 10mm pockets on the disto-buccal and disto-lingual aspects of tooth #14, and 5 and 6mm pockets on the mesio-lingual and mesio-buccal aspects of tooth #15 respectively. Also noted on the periodontal chart was the presence of a draining fistula and a periodontal abscess in the disto-buccal area of tooth #2. Though Licensee examined the patient on February 13, 1996, he failed to refer him to a periodontist. Instead, Licensee completed a pre-authorization form and through the use of CDT code 4260, indicated he planned to provide osseous surgery to teeth #2, 3, and 14.

3) On February 21, 1996, Licensee noted he performed "Perio surg," on teeth #2, and 14 and 15 of patient 3 but listed the billing code for osseous surgery. In the "Surface" section of the progress notes Licensee wrote, "3.6 cc lido[caine with] epi[nephrine], open and incise, scale and curettage [of teeth]#11-12, 13-14, abscess cleaned out on #3, class II

mobility on #14, 15, 3." Though Licensee saw patient 3 for restorative treatment in March, April, and May, Licensee failed to follow up on the patient's periodontal status until ten months later on December 12, 1996, when the patient received a prophylaxis. At his conference with the Committee, Licensee stated that he was without sufficient knowledge to admit or deny that he failed to follow up on the patient's status until December 12, 1996.

4) On December 12, 1996, patient 3 received an examination and a "perio maintenance" prophylaxis, and one periapical and four bitewing radiographs were taken of the patient's teeth. According to the results of periodontal probing, there were 4 and 5 mm pockets on the mesio-buccal and buccal aspects and 8mm pockets on the disto-buccal and disto-lingual aspects of tooth #2, 8mm pockets on the disto-buccal and disto-lingual aspects of tooth #14, 5 and 6mm pockets on the mesio-lingual and mesio-buccal aspects of tooth #15 respectively, and 4 and 5mm pockets on the lingual aspects of teeth #19, 30, and 31. Also noted on the periodontal chart, "[P]ockets same, UR doesn't hurt as much." The progress notes indicated a plan for the patient to return for a six-month recall appointment.

5) On August 13, 1997, patient 3 received a "perio maintenance" prophylaxis. A notation indicating Licensee had examined the patient was crossed out of the patient's progress notes. According to the results of periodontal probing, there was a 4mm pocket on the facial and an 8mm pocket on the disto-buccal aspect of tooth #2, a 9mm pocket on the disto-buccal and an 8mm pocket on the disto-lingual aspect of tooth #14, 8mm pockets on the mesio-buccal and mesio-lingual aspects of tooth #15, and 5mm pockets on the disto-buccal and disto-lingual aspects of tooth #31. Also noted on the periodontal chart, "[P]ockets stable, #14 & 15-cl. II mobility, bone 'spongy' re-eval next appt., Deep scaled all, deep sub[gingival]

calc[ulus]. Plan 4[month recall]; take FMX then." The patient's progress notes listed the same plan.

6) On December 3, 1997, patient 3 received a "perio maintenance" prophylaxis and a full mouth series of radiographs were taken. The patient's progress notes contained no indication that Licensee examined the patient or reviewed his radiographs other than the note, "Refer to [Endodontist's name]." According to the results of periodontal probing, there was a 6mm pocket on the buccal and a 7mm pocket on the disto-buccal aspect of tooth #2, a 9mm pocket on the disto-buccal and an 8mm pocket on the disto-lingual aspect of tooth #14, a 5mm pocket on the buccal, a 9mm pocket on the mesio-buccal and an 8mm pocket on the mesio-lingual aspect of tooth #15, 4 and 5mm pockets on the lingual of tooth #19, and 4 and 5mm pockets on the buccal and lingual aspects of teeth #30 and 31. Also noted on the periodontal chart, "Fistula #2 DB, exudate # 14-15, sub calc. post[erior]."

7) On January 8, 1998, Licensee noted, "Splint with [illegible], explained need for extraction [of teeth #]2, 14, 15 and implants." Licensee failed to indicate the reason for seeing the patient on this date and to note which teeth were splinted. On a phone message slip of this date it was noted that the endodontist had reported that one or two of patient 3's teeth might need to be removed. In an unsigned, handwritten note dated January 8, 1998, which was found in the patient's chart, a member of Licensee's staff wrote, "Prognosis not good on any 3T[eeth] per [endodontist]. Chance surgical procedure or EXT[ract]=Bridge." On an oral surgery group referral slip dated January 8, 1998, Licensee indicated teeth #2, 14, and 15 of patient 3 were to be extracted and wrote, "Please remove [the teeth indicated] and consultation (sic) for implants."

8) On February 18, 1998, Licensee noted he provided osseous surgery to teeth #14 and 15 of patient 3, but failed to document the appropriate information concerning the procedure. The patient's progress notes contained a hand drawn schematic of the quadrants around teeth #13-15, indicating pockets on those teeth ranged from 9-12mm. Though he had just provided osseous surgery to teeth #14 and 15, on an oral surgery group referral slip filled out the day of the surgery, Licensee indicated teeth #2, 14, and 15 of patient 3 were to be extracted and wrote, "Consult (sic) for implate [implants]."

9) Licensee submitted a bill for the quadrant of osseous surgery to patient 3's insurer for which payment was denied on February 27, 1998. On March 12, 1998, patient 3 paid for the surgery.

10) In a letter dated March 16, 1998, an oral surgeon informed Licensee that he had consulted with patient 3 and found that "Teeth #14 and 15 are acutely abscessed with bone loss all the way to the floor of the sinus. They are quite mobile and have responded well from a comfort standpoint to the Sumycin. However, this is only buying a short period of time before [an] acute flare-up will occur again." The oral surgeon reported that an appointment for the extraction of teeth #14 and 15 had been set for April 13, 1998, less than two months after Licensee provided osseous surgery to these teeth.

11) On April 13, 1998, the oral surgeon extracted teeth #14 and 15 of patient 3. At subsequent appointments on July 15, and October 28, 1998; July 14, 1999; and March 13, and August 29, 2000; patient 3 received examinations and prophylaxes. Bitewing radiographs were taken only at the August 29, 2000 appointment and Licensee failed to record the results of periodontal probing at the appointments in 1999 and 2000. Review of the August 29, 2000 bitewing radiographs and the results of periodontal probing performed at two

appointments in 1998 revealed the patient's compromised periodontal status. According to the patient's progress notes, in 1999 patient 3 was diagnosed as having type II or III periodontitis and in 2000, as having type I or II periodontitis.

d. At patient 4's prophylaxis appointments on July 28, 1999, February 9, May 9, August 15, and November 20, 2000, Licensee and his staff failed to complete an oral screening form to document the results of periodontal probing for the patient's entire mouth. In the progress notes for several of those appointments, it was noted that the implant in the site of tooth #31 had a 6mm pocket that may have been the cause of a bad taste in the patient's mouth. In the progress notes for August 15, 2000, the presence of a 4mm pocket on the implant at the site of tooth #29 was also noted. At the prophylaxis appointment on November 20, 2000, two bitewing radiographs were taken which showed significant bone loss around teeth #29 and 31. As of that date, Licensee had not noted a plan to refer the patient to a periodontist for treatment of the implants.

Substandard Diagnosis and Treatment Planning

2. Licensee has failed to provide appropriate diagnoses and/or to formulate appropriate treatment plans for his patients. Examples include the following:

a. Licensee failed to note the presence of an abscess on tooth #30 of patient 6. On January 20, 1998, patient 6 was seen for an initial examination and a periodontal evaluation, and a full mouth series of radiographs was taken. Licensee failed to note the abscess on the disto-buccal root of tooth #30 seen on those radiographs. On January 26, 1998, Licensee placed crowns on teeth #17-19 of patient 6, and saw the patient at four scaling and root planing appointments in February, but Licensee failed to note the presence of the abscess on tooth #30. On February 26, 1998, Licensee performed build-ups and placed crowns on teeth #30-32,

without first noting and treating the abscess on tooth #30. As of March 2, 2000, Licensee had failed to treat tooth #30's abscess.

b. Licensee failed to address radiolucency on tooth #1 of patient 7. On May 20, 1998, patient 7 was seen for an examination and prophylaxis, and root canal therapy and a post and bridge preparation on tooth #20. Also though not noted in the patient's progress notes, three bitewing radiographs were taken. As seen on two of the radiographs, there is a radiolucency on the mesial margin of tooth #1, the distal abutment of a five-unit bridge on the maxillary right of the patient's mouth. Licensee failed to note the radiolucency. On October 29, 1998, patient 7 was seen for an emergency examination, and the following was noted, "Patient feels upper right bridge 5 unit (sic) is loose. [Licensee] checked bridge said it doesn't feel loose, there is no decay around the bridge."

c. On October 27, 1999, Licensee inappropriately performed a build-up and placed a mesio-bucco-disto-occlusal onlay on tooth #5 of patient 3, without first taking a preoperative periapical radiograph of the tooth. Though Licensee had taken four bitewings radiographs of the patient at a prophylaxis appointment on July 14, 1999, the most recent periapical radiographs of tooth #5 were part of a full mouth series of radiographs taken on December 3, 1997.

Substandard Endodontic and Prosthodontic Treatment

3. Licensee has failed to provide appropriate endodontic and prosthodontic treatment to one or more of his patients. Examples include the following:

a. Licensee inappropriately provided root canal therapy to tooth #10 and placed crowns on compromised teeth #9 and #10 of patient 8. In addition, less than two weeks

after the crown was seated on tooth #10; the tooth fractured and was extracted, as described below:

1) On August 14, 1997, Licensee noted he provided root canal therapy to tooth #10, and placed a cast post and core and a crown on the tooth. Licensee also performed a crown build-up and placed a crown on tooth #9. One of two-undated periapical radiographs in the patient's chart showed root canal therapy in progress on tooth #10 but did not include the apex of the tooth's root. Both radiographs showed over 50% vertical bone loss around teeth #9 and 10.

2) On August 26, and September 7, 1997, Licensee seated the crowns on teeth 9 and 10 of patient 8.

3) Four days later on September 11, 1997, Licensee extracted tooth #10 of patient 8 and prepared teeth #9 and 11 for a bridge. In the surface section of the progress notes Licensee noted, "Broke off [tooth] #10 below gumline, large split vertical[,] explained bridge."

b. Licensee initiated root canal therapy without first taking a periapical radiograph of tooth #20 and replaced a cantilevered bridge on periodontally compromised tooth #20 of patient 7. On May 20, 1998, Licensee saw patient 7 for an examination and prophylaxis, and took three bitewing radiographs. One bitewing radiograph showed a cantilevered bridge from tooth #20-19 and that tooth #20 had significant loss of tooth. On that same date, Licensee performed root canal therapy, placed a post, and prepared tooth #20 for a crown with a cantilevered pontic of tooth #19; all without first taking a periapical radiograph. On June 4, 1998, Licensee seated the crown on tooth #20. An undated periapical radiograph taken after the placement of the cantilevered bridge on tooth #20 showed bone loss on the mesial

and distal aspects of the tooth. At his conference with the Committee, Licensee stated that he was without sufficient knowledge to admit or deny that he failed to follow up on the patient's status until December 12, 1996.

c. Licensee placed an inadequate crown on tooth #3 of patient 9, and failed to provide root canal therapy to the tooth in a timely manner, as follows:

1) Patient 9 had been a patient of record at Licensee's office since 1979. While on vacation in Arizona in March 1999, patient 9 had a toothache and sought treatment from an Arizona dentist who took a radiograph and performed vitality testing on the tooth before recommending root canal therapy. Since patient 9 planned to return to Minnesota the next day, the dentist gave her a prescription for a pain medication, but did not initiate treatment on the tooth.

2) On March 16, 1999, Licensee saw patient 9 and she showed him the radiograph taken by the Arizona dentist. Licensee told patient 9 that she would have to make another appointment to have a crown placed on the tooth and that the adjacent tooth also needed a crown. When patient 9 told Licensee that the Arizona dentist had recommended root canal therapy for the tooth, Licensee told her that would not be necessary. In the patient's progress notes Licensee noted he provided palliative treatment to teeth #3 and 4 of patient 9 and a plan to place crowns on both teeth.

3) On March 25, 1999, Licensee noted he placed a core build-up and a Cerec crown on tooth #3, and a post and core and Cerec crown on tooth #4. According to patient 9, Licensee made one crown for her at chair-side and placed it on tooth #4, but after preparing tooth #3, he did not put a crown on the tooth and its sharp edges irritated the patient's cheek.

4) On March 29, 1999, Licensee noted he checked tooth #3, without describing the patient's complaint or taking a radiograph of the tooth. According to patient 9, Licensee placed the crown on tooth #3. When patient 9 said the crown felt too close to the other tooth, the dental assistant told her the cement used to seat the crown would cause it to feel tight. At his conference with the Committee, Licensee stated that he was without sufficient knowledge to admit or deny that he failed to describe the patient's complaint.

5) In April 1999, patient 9 called Licensee's office to report the presence of a lump on the gingiva apical to tooth #3 and was told if it didn't hurt, patient 9 could just wait to have it checked until her next prophylaxis appointment. This telephone conversation was not noted in the patient's progress notes.

6) On May 27, 1999, patient 9 was seen for an examination and prophylaxis, and four bitewing radiographs were taken. On the "Oral Screening" form, the dental hygienist noted the presence of the bump and also heavy cement around teeth #3 and 4. On that form and in the patient's progress notes, the dental hygienist noted a plan to refer patient 9 to an endodontist for treatment of tooth #3. During the examination, Licensee told patient 9 there was excess cement on the crown on tooth #3, but she would have to make another appointment to have it removed. When patient 9 told Licensee about the bump near tooth #3 and how she had talked to his receptionist about it on the phone, he told her that he didn't have time to take care of it that day. Licensee explained that a root canal was needed to take care of the bump and that he required a two and half hour appointment for root canal therapy and removal of the excess cement.

7) In his June 29, 2000, letter responding to the Committee's letter of inquiry regarding patient 9, Licensee provided two conflicting statements about the patient's

appointment on May 27, 1999. He wrote, "I found some drainage on the bump, and tooth 3 did not need endodontic therapy. I offered to remove some cement for her when she came in for the root canal on number 3." At his conference with the Committee, Licensee stated that he was without sufficient knowledge to admit or deny this allegation.

8) According to the patient's computerized progress notes, patient 9 was seen on June 14, 1999. The patient reported that she was put in a dental chair and the dental hygienist looked at her tooth. Patient 9 said that she was told that Licensee would be right with her and, though she waited quite a while, she was finally informed that Licensee did not have time to see her that day. The progress notes stated, "S: Patient presents for check (sic) tooth #3 today. O: Abscess noticed at last prophy appt. Was wondering about bump on tooth. She has had some draining at area of bump. A: Needs to have some cement removed from between #2 and #3. Patient feels frustrated that she has to come back to have cement removed. P: Patient needs to schedule for root canal treatment on tooth #3 soon. The root may be cracked and [the tooth] may need an extraction."

9) On December 17, 1999, patient 9 sought treatment from a subsequent treating dentist who referred her to an endodontist for treatment of tooth #3.

10) In a letter dated January 25, 2000, the endodontist informed the subsequent treating dentist that clinical and radiographic examination had shown that tooth #3 of patient 9 needed endodontic therapy and an appointment for that purpose had been scheduled. The endodontist added, "In addition to the root canal, I would strongly recommend that a new crown be made. The existing crown appears to be some sort of prefabricated crown that was made chair-side in one appointment. The crown seems to be poor fitting, with a significant mesial overhang and a lingual marginal gap."

d. Licensee failed to provide adequate prosthetic crown restorations on teeth #3 and #4 for patient 24.

1) On or about November 7, 2001, Licensee referred patient 24 to an endodontist to provide root canal treatment on teeth #3 and #4. Following endodontic treatment, Licensee proceeded to provide prosthetic crowns on teeth #3 and #4. On or about December 3, 2001, patient 24 saw Licensee because the crown on tooth #4 had a ridge near the gingival where food got caught which was adjusted by Licensee. At his conference with the Committee, Licensee stated that he was without sufficient knowledge to admit or deny this allegation.

2) On August 1, 2002, patient 24 saw her subsequent treating dentist because the crown on tooth #3 came off. The subsequent treating dentist indicated in the patient's progress notes that tooth #3 lacked a crown build-up and the crown itself was extended into the chamber of the tooth. He also indicated the following future treatment for patient 24 for both teeth #3 and #4: posts, crown build-ups, and re-preps for new crowns. At his conference with the Committee, Licensee stated that he was without sufficient knowledge to admit or deny this allegation

e. For patient 25, Licensee failed to provide adequate prosthetic restorations on teeth #2 and #3.

1) On April 18, 2000, Licensee provided a porcelain/ceramic crown on tooth #2 and a porcelain onlay on tooth #3 for patient 25. On May 3, 2001, patient 25 returned to the State of Minnesota to have Licensee examine tooth #2 where a portion of her crown had broken off. Licensee repaired the crown with a bonding material at that same appointment. However about four months later, patient 25 claims that the same tooth came apart again.

2) According to an undated letter from patient 25's subsequent treating dentist in Tennessee, he examined the patient on January 31st [2002] and her chief complaint was tooth #2. He also noted that the porcelain onlay [tooth #3] was fractured on the lingual surface, had a hole in the occlusal surface, and had an open embrasure on the mesial contact adjacent to tooth #4. Moreover, the subsequent treating dentist stated that he re-prepared tooth #2 for a new crown on patient 25. No other future dental treatment was mentioned in the letter.

f. Licensee failed to provide adequate prosthetic restorations on teeth #18, #19, and #29 for patient 26.

1) In March 1994 and on July 31, 1996, for patient 26, Licensee provided a gold onlay on tooth #19 and a full gold crown on tooth #18, respectively. On February 26, 2001, the patient's subsequent treating dentist re-prepared teeth #18 and #19 for new crowns because of the following as evident on the full mouth radiographs dated January 30, 2001: the previous crown on tooth #18 was open on the distal margin; the previous onlay on tooth #19 was short on the distal margin/overextended on the mesial margin; and both the crown and onlay had clinical decay underneath.

2) On March 31, 1999, Licensee provided a porcelain crown on tooth #29 for patient 26. On March 19, 2002, the patient's subsequent treating dentist re-prepared tooth #29 for a new crown because the previous crown was short on the distal margin as evident on the full mouth radiographs dated January 30, 2001.

g. Licensee failed to provide an adequate prosthetic crown restoration on tooth #20 for patient 27. On February 25, 1999, Licensee provided a porcelain (Cerec) crown on tooth #20. This same crown came off the tooth and was recemented on September 27, 1999. On

May 8, 2001, patient 27's subsequent treating dentist re-prepared tooth #20 for a new crown because the previous crown was short on the distal margin as evident on the full mouth radiographs dated January 25, 2001.

Inadequate Safety and Sanitary Conditions

4. During interviews with an investigator from the Attorney General's Office ("investigator") in 1999, various members of Licensee's staff reported observing Licensee engage in conduct which failed to comply with the Centers for Disease Control's (CDC) and the Occupational Safety and Health Administration (OSHA) most current guidelines for infection control in a dental office. During an office visit conducted on January 14, 1999, for the purpose inspecting Licensee's office and interviewing Licensee, two AG investigators noted that Licensee failed to maintain adequate safety and sanitary conditions for his dental office, as described below:

a. Licensee opened operatory drawers and retrieved instruments or materials while wearing contaminated gloves, exposing the rest of the drawer's contents to contamination. When asked about this conduct during his interview, Licensee told the investigators that it was possible that he did this if he did not have cotton pliers available to him at the time. He stated that he did not make a routine practice of wearing his contaminated gloves when retrieving items from operatory drawers.

b. On occasion, Licensee failed to remove his contaminated gloves before making an entry in a patient's chart.

c. Licensee failed to remove his contaminated gloves before leaving an operatory and have subsequently removed them and left the contaminated gloves on the counter

at the receptionist's desk. At his conference with the Committee, Licensee stated that he was without sufficient knowledge to admit or deny this allegation

d. Licensee failed to adequately explain or describe how he disposes hazardous waste from his office. At a staff meeting Licensee's staff asked him how he disposed of the hazardous waste containing amalgam and other debris from the building's main compressor and Licensee told them that he dumped the waste down the drain in the building's underground garage. But when the investigators asked him to explain how he disposed of hazardous waste from his office's suction traps, Licensee said that the waste is collected into a single vacuum pump located in the building's garage. Licensee explained that there is no liquid in the vacuum pump and the waste is "red bagged" or if there is "nothing in there," it is placed in the garbage. When asked whether he had ever told his staff that he dumped the main trap into the garage drain, Licensee denied saying that and explained that the issue was never discussed at a staff meeting. Licensee also said that there is no underground drain in the garage except for one that collects runoff and sends it into the city sewer line. At his conference with the Committee, Licensee stated that he was without sufficient knowledge to admit or deny this allegation.

e. On occasion, Licensee failed to place barriers on the handpiece bases and hoses, ultrasonic scaler, composite curing light, and x-ray machine located in Licensee's operatory.

f. On occasion, Licensee failed to maintain the sterility of autoclaved items in that some dental and surgery instruments, handpieces, and syringes were removed from their autoclave bags and stored loose in operatory drawers. When shown photographs of unbagged items stored in an operatory drawer, Licensee told the investigators that this was the assistant's

drawer and the items could have been spares. When asked whether even spares should be stored in bags, Licensee said, "Probably should have, yes."

g. On occasion, Licensee and/or his staff failed to wear utility gloves instead of exam gloves when decontaminating instruments in the lab area. At the conference, Licensee stated that staff uses latex gloves for processing contaminated instruments.

h. During his interview Licensee admitted that he had previously stored dental materials and food items in the same refrigerator and explained that he had added a refrigerator when he moved his office in 1999.

i. Licensee failed to properly follow laundering guidelines for personal protective equipment; instead he had staff members launder their scrub uniforms at home. He also stated that his staff does not wear gloves when handling contaminated garments for laundry.

Improper Prescribing

5. Licensee has prescribed medication improperly to himself, his family, and one or more of his patients, as follows:

a. Licensee overprescribed controlled substances to patient 10. With the exception of patient 10's first five appointments in 1985, an appointment on July 28, 1996, and one on September 15, 1994, Licensee prescribed at least six (6) tablets of Percodan at the majority of the patient's appointments with Licensee. Specifically, at nineteen appointments from July 26, 1986, to May 19, 1997, Licensee prescribed at least six, but usually 15, and occasionally up to 29 tablets of Percodan to patient 10. Though Licensee maintained copies of the prescriptions in the patient's file, he failed to note them in the patient's progress notes. One of those prescription copies was undated and another is dated "5-31-9-. The latter copy did not correspond with any progress note dates.

b. Licensee has improperly prescribed medications for himself and for his family. During his interview with the investigators, Licensee admitted that he prescribed antibiotics for himself after a tooth extraction and antibiotics for his three sons for ear infections. He also admitted renewing a beta-blocker prescription for his wife and prescribing amoxicillin and penicillin, diazepam, ibuprofen (800 mg), Tylenol #3, Anusol, and hydrocortisone for her. When asked about the propriety of a dentist prescribing medications for himself and for his family for non-dental purposes, Licensee replied, "Shouldn't do it."

Improper Administration of Nitrous Oxide Inhalation Analgesia and Anesthetic

6. Licensee has improperly administered inhalation analgesia and anesthetic to one or more of his patients, as follows:

a. At two appointments in 1993, Licensee administered an unusual mix of nitrous oxide and oxygen to patient 10. According to the patient's progress notes, on August 3, 1993, Licensee administered nitrous oxide to patient 10 using a ratio of 7:4 and on August 18, 1993, using a ratio of 7:3. At the appointment on August 18, 1993, it was noted, "Patient always wants more gas."

b. At patient 25's initial examination appointment on November 29, 1999, she completed a medical history form and in response to the question, "Are you allergic to or do you suffer ill effects from any of the following?" she wrote "Feel panicky, heart beats too fast" next to the words "Dental Anesthesia." Despite this, Licensee used a local anesthesia on patient 25 that contained epinephrine on February 28, March 9, and May 8, 2000. At one of her appointments, patient 25 recalled how frightened she was when her heart beat increased and her entire body trembled from being given anesthetic with epinephrine.

Substandard Recordkeeping

7. Licensee has failed to make or maintain adequate records for his patients. Examples include the following:

a. Licensee failed to obtain medical histories on patients 9, 12, and 13.

b. Licensee failed to consistently update medical histories on patients 1, 3, 4, 5, 6, 8, 11, 14, 15, 16, 18, 20, 21, and 22.

c. In all patient records reviewed by the Committee, Licensee failed to consistently: make adequate narrative progress notes; document prescriptions; document a diagnosis and treatment plan; identify all medications he used and all the materials he placed; and indicate that he obtained the patient's consent to the treatment he provided. During the interview, Licensee told the investigators about his computer software program, explaining that the computer lays out a standardized "SOAP" format for each visit, so the staff will not "forget anything." Though Licensee's computerized progress notes were more legible and provided more detail, Licensee failed to consistently document a diagnosis and treatment plan, the appropriate information about the type of local anesthetic administered and whether he obtained a patient's consent to treatment. Examples include the following:

1) On February 18, 1998, Licensee noted he provided osseous surgery to teeth #14 and 15 of patient 3, but failed to note whether he administered local anesthetic, and whether sutures were placed and postoperative instructions were given to the patient.

2) On March 25, 1999, Licensee prepared teeth #3 and 4 of patient 9 for crowns but failed to note whether he administered local anesthetic to the patient.

d. Licensee failed to complete a record of existing oral health status for patients 1, 3-15, 17-21 and 23.

e. Licensee failed to adequately maintain all periodontal probing charts in patient 14's record when providing periodontal care.

f. Licensee failed to make or maintain adequate radiographic records for his patients in that the radiographic records contained a number of undated radiographs for the following patients:

Patient Number	# of radiographs
1	1
3	6
4	5
5	4
7	7
8	13
10	5
11	1
12	2
14	4
17	1
18	2
19	7

C. Violations. Licensee admits that the facts and conduct specified above constitute violations of Minn. Stat. § 150A.08, subd. 1(6) and Minn. R. 3100.6200B (repeated performance of dental treatment which falls below accepted standards); Minn. Stat. § 150A.08, subd. 1(5) (improper prescribing of a legend drug, chemical or controlled substance); Minn. Stat. § 150A.08, subd. 1(10) and Minn. R. 3100.6200 K and 3100.6300 (failure to maintain adequate safety and sanitary conditions for a dental office); and Minn. R. 3100.9600 (failure to maintain adequate patient records) and are sufficient grounds for the disciplinary action specified below.

D. Disciplinary Action. Licensee and the Committee recommend that the Board issue an order which places CONDITIONS on Licensee's license to practice dentistry in the State of Minnesota as follows:

CONDITIONS

1. Coursework. Within one year of the effective date of this order, Licensee shall successfully complete the coursework described below. All coursework must be approved in advance by the Committee. Licensee is responsible for locating, registering for, and paying for all coursework taken pursuant to this stipulation and order. If Licensee attends an undergraduate or graduate dental school course, Licensee must provide each instructor with a copy of this stipulation and order prior to commencing a course. Licensee shall pass all courses with a grade of 70 percent or a letter grade "C" or better. Licensee's signature on this stipulation and order constitutes authorization for the course instructor(s) to provide the Committee with a copy of the final examination and answers for any course Licensee takes. Licensee's signature also authorizes the Committee to communicate with the instructor(s) before, during, and after Licensee takes the course about Licensee's needs, performance and progress. None of the coursework taken pursuant to this stipulation and order may be used by Licensee to satisfy any of the continuing dental education requirements of Minn. R. 3100.4100, subps. 1 and 2. The coursework is as follows:

a. Periodontic Coursework. Within one year of the effective date of this order, Licensee must complete a minimum of 6 hours of instruction in periodontics, emphasizing diagnoses and timely referrals.

b. Treatment Planning Coursework. Within one year of the effective date of this order, Licensee successfully complete the Special Course on Treatment Planning (a

minimum of 40 hours of individualized instruction) offered in the summer by the University of Minnesota or an equivalent course.

c. Recordkeeping and Risk Management Coursework. Within one year of the effective date of this order, Licensee shall complete a minimum of 6 hours of instruction on recordkeeping and risk management.

d. Ethics. Within one year of the effective date of this order, Licensee shall complete an individually designed course in ethics offered by Dr. Muriel Bebeau at the University of Minnesota Dental School. Licensee's signature on this stipulation and order is authorization for Dr. Bebeau and the Committee to communicate regarding Licensee's needs, performance and progress before, during, and after Licensee takes the course.

2. Written Reports and Information. Licensee shall submit or cause to be submitted to the Board the reports and/or information described below. All reports and information are subject to approval by the Committee:

a. Within 30 days of completing any coursework taken pursuant to paragraph 1 above, Licensee shall submit to the Board (a) a transcript or other documentation verifying that Licensee has successfully completed the course, if the course is a graduate or undergraduate dental school course, (b) a copy of all materials used and/or distributed in the course, and (c) a written report summarizing what Licensee learned in the course and how Licensee has implemented this knowledge into Licensee's practice. Licensee's report shall be typewritten in Licensee's own words, double—spaced, at least two and no more than three pages in length, and must list references used to prepare the report. The report for the recordkeeping consultation shall include sample recordkeeping forms that Licensee has begun to use in his practice.

b. Infection Control Protocol. Within one year of the effective date of this order, Licensee shall submit to the Committee for approval a copy of the written protocol establishing infection control procedures for use in his office. Licensee's written protocol must reflect the Center for Disease Control (CDC) 2003 guidelines. Licensee shall include in the report an explanation of the changes made in his office's infection control protocols due to the CDC 2003 guidelines.

c. Additional Reports. Within one year of the effective date of this order, Licensee shall submit two additional reports. One report must address Licensee's protocol for the administration of nitrous oxide, emphasizing the difference between child and adult titration; the other must address techniques Licensee uses in crown and bridge preparation, including taking impressions and crown seating techniques. The reports must be in Licensee's own words, double-spaced, at least two pages and nor more than three pages in length and must list references used to prepare the report

d. Office Inspection. Within three months of Licensee's successful completion of all coursework described above and submission of the reports and protocol described above, Licensee shall cooperate with at least one unannounced office visit by a representative of the Board for the purpose of reviewing Licensee's recordkeeping practices and inspecting the safety and sanitary conditions of Licensee's office. The Board's representative shall inspect Licensee's dental office during normal office hours and randomly choose and temporarily remove five to ten original patient records for duplication and review by the Committee. Licensee shall fully and timely cooperate with such inspections of Licensee's office and patient records.

3. Jurisprudence Examination. Within 90 days of the effective date of this stipulation and order, Licensee shall take and pass the Minnesota jurisprudence examination with a score of at least 90 percent. Licensee may take the jurisprudence examination with the 90-day period as many times as necessary to attain a score of 90 percent, however, Licensee may take the examination only once each day. Within 10 days of each date Licensee takes the jurisprudence examination, Board staff will notify Licensee in writing of the score attained.

4. Reimbursement of Costs. Licensee shall pay the Board the sum of $10,000 as partial reimbursement for the Board's costs in this matter. All payments shall be made by certified check, cashier's check, or money order made payable to the Minnesota Board of Dentistry in two installments, as follows: $5,000 dollars within 60 days of the effective date of this order, and $5,000 by the time Licensee petitions to have the conditions removed from his license.

5. Other Conditions.

a. Licensee shall comply with the laws or rules of the Board of Dentistry. Licensee agrees that failure to comply with the Board's laws or rules shall be a violation of this stipulation and order.

b. Licensee shall fully and promptly cooperate with the Board's reasonable requests concerning compliance with this stipulation and order, including requests for explanations, documents, office inspections, and/or appearances at conferences. Minn. R. 3100.6350 shall be applicable to such requests.

c. If the Board receives a complaint alleging additional misconduct or deems it necessary to evaluate Licensee's compliance with this stipulation and order, the Board's authorized representatives shall have the right to inspect Licensee's dental office(s) during

normal office hours without prior notification and to select and temporarily remove original patient records for duplication. Licensee shall fully and timely cooperate with such inspections of Licensee's office and patient records.

d. In the event Licensee should leave Minnesota to reside or practice outside the state, Licensee shall notify the Board in writing of the new location within five days. Periods of residency or practice outside of Minnesota will not apply to the reduction of any period of Licensee's discipline in Minnesota unless Licensee demonstrates that practice in another state conforms completely to this stipulation and order.

E. Removal of Conditions. Licensee may petition to have the conditions removed from Licensee's license at any regularly scheduled Board meeting no sooner than one year after the effective date of this order provided that Licensee's petition is received by the Board at least 30 days prior to the Board meeting. Licensee shall have the burden of proving that Licensee has complied with the foregoing and that Licensee is qualified to practice dentistry without conditions. Licensee's compliance with the foregoing requirements shall not create a presumption that the conditions should be removed. Upon consideration of the evidence submitted by Licensee or obtained through Board investigation, the Board may remove, amend, or continue the conditions imposed by this order.

F. Fine for Violation of Order. If information or a report required by this stipulation and order is not submitted to the Board by the due date, or if Licensee otherwise violates this stipulation and order, the Committee may fine Licensee $100 per late report or other violation. Licensee shall pay the fine and correct the violation within five days after service on Licensee of a demand for payment and correction. If Licensee fails to do so, the Committee may impose additional fines not to exceed $500 per violation. The total of all fines may not exceed $5,000.

Licensee waives the right to seek review of the imposition of these fines under the Administrative Procedure Act, by writ of certiorari under Minn. Stat. § 480A.06, by application to the Board, or otherwise. Neither the imposition of fines nor correction of the violation will deprive the Board of the right to impose additional discipline based on the violation.

G. Additional Discipline for Violation of Order. If Licensee violates this stipulation and order, Minn. Stat. ch. 150A, or Minn. R. ch. 3100, the Board may impose additional discipline pursuant to the following procedure:

1. The Committee shall schedule a hearing before the Board. At least ten days prior to the hearing, the Committee shall mail Licensee a notice of the violation alleged by the Committee and of the time and place of the hearing. Within seven days after the notice is mailed, Licensee shall submit a response to the allegations. If Licensee does not submit a timely response to the Board, the allegations may be deemed admitted.

2. At the hearing before the Board, the Committee and Licensee may submit affidavits made on personal knowledge and argument based on the record in support of their positions. The evidentiary record before the Board shall be limited to such affidavits and this stipulation and order. Licensee waives a hearing before an administrative law judge and waives discovery, cross-examination of adverse witnesses, and other procedures governing administrative hearings or civil trials.

3. At the hearing, the Board will determine whether to impose additional disciplinary action, including additional conditions or limitations on Licensee's practice, or suspension or revocation of Licensee's license.

H. Other Procedures for Resolution of Alleged Violations. Violation of this stipulation and order shall be considered a violation of Minn. Stat. § 150A.08, subd. 1(13). The

Committee shall have the right to attempt to resolve an alleged violation of the stipulation and order through the procedures of Minn. Stat. § 214.103, subd. 6. Nothing herein shall limit (1) the Committee's right to initiate a proceeding against Licensee pursuant to Minn. Stat. ch. 14, or (2) the Committee's and the Board's right to temporarily suspend Licensee pursuant to Minn. Stat. § 150A.08, subd. 8, based on a violation of this stipulation and order or based on conduct of Licensee before or after the date of this stipulation which is not specifically referred to in paragraph B. above.

I. Attendance at Conference. Licensee and his attorney, Philip G. Villaume, 5200 Willson Road, Suite 150, Edina, Minnesota attended a conference with the Committee on January 16, 2004. The following Committee members attended the conference: Nadene Bunge, D.H., Ronald King, D.D.S., and Freeman Rosenblum, D.D.S. Assistant Attorney General Rosellen Condon represented the Committee at the conference. Licensee continues to be represented by Philip G. Villaume, who has advised Licensee regarding this stipulation and order.

J. Waiver of Licensee's Rights. For the purpose of this stipulation, Licensee waives all procedures and proceedings before the Board to which Licensee may be entitled under the Minnesota and United States constitutions, statutes, or the rules of the Board, including the right to dispute the facts contained in this stipulation and order and to dispute the appropriateness of discipline in a contested proceeding pursuant to Minn. Stat. ch. 14. Licensee agrees that upon the application of the Committee without notice to or an appearance by Licensee, the Board may issue an order imposing the discipline specified herein. The Committee may participate in Board deliberations and voting concerning the stipulation. Licensee waives the right to any judicial review of the order by appeal, writ of certiorari, or otherwise.

K. Board Rejection of Stipulation and Order. In the event the Board in its discretion does not approve this stipulation or a lesser remedy than specified herein, this stipulation and order shall be null and void and shall not be used for any purpose by either party hereto. If this stipulation is not approved and a contested case proceeding is initiated pursuant to Minn. Stat. ch. 14 and section 150A.08, Licensee agrees not to object to the Board's initiation of the proceeding and hearing the case on the basis that the Board has become disqualified due to its review and consideration of this stipulation and the record.

L. Record. This stipulation, related investigative reports and other documents shall constitute the entire record of the proceedings herein upon which the order is based. The investigative reports, other documents, or summaries thereof may be filed with the Board with this stipulation. Any reports or other material related to this matter which are received after the date the Board approves the stipulation and order shall become a part of the record and may be considered by the Board in future aspects of this proceeding.

M. Data Classification. Under the Minnesota Data Practices Act, this stipulation and order is classified as public data. Minn. Stat. § 13.41, subd. 5. All documents in the record shall maintain the data classification to which they are entitled under the Minnesota Government Data Practices Act, Minn. Stat. ch. 13. They shall not, to the extent they are not already public documents, become public merely because they are referenced herein. Pursuant to federal rule (45 C.F.R. part 60), the Board must report the disciplinary action contained in this stipulation and order to the National Practitioner Data Bank.

N. Entire Agreement. Licensee has read, understood, and agreed to this stipulation and is freely and voluntarily signing it. This stipulation contains the entire agreement between

the parties hereto. Licensee is not relying on any other agreement or representations of any kind, verbal or otherwise.

O. Service and Effective Date. If approved by the Board, a copy of this stipulation and order shall be served personally or by first class mail on Licensee's legal counsel. The order shall be effective and deemed issued when it is signed by the President or Vice-President of the Board.

LICENSEE

JOHN POAGE, D.D.S.

Dated: March 16, 2004

By:

COMPLAINT COMMITTEE

MARSHALL SHRAGG
Executive Director

Dated: 3/19/04

ORDER

Upon consideration of the foregoing stipulation and based upon all the files, records, and proceedings herein,

The terms of the stipulation are approved and adopted, the recommended disciplinary action set forth in the stipulation is hereby issued as an order of this Board placing CONDITIONS on Licensee's license effective this 26th day of March, 2004.

MINNESOTA BOARD
OF DENTISTRY

By: _____
LINDA BOYUM
PRESIDENT

AG: #998374-v1